AMENDMENT TO VENDOR AGREEMENT # _____ Name _____

Rhode Island Department of Health

WIC Program

HISTORY OF STORE OWNERSHIP

What length of time has this store operated in this present location under present ownership? _____

Has there been a change or modification in ownership such as:

Partner(s) added	Yes ☐	No ☐	Date: ___/___/___
Deleted partner(s)	Yes ☐	No ☐	Date: ___/___/___
Corporation merger	Yes ☐	No ☐	Date: ___/___/___
Changed to sole ownership	Yes ☐	No ☐	Date: ___/___/___
Changed to partnership	Yes ☐	No ☐	Date: ___/___/___
Changed to corporation	Yes ☐	No ☐	Date: ___/___/___
"Trial" ownership	Yes ☐	No ☐	Date: ___/___/___
"Purchase or Sales" Agreement	Yes ☐	No ☐	Date: ___/___/___
Temporary ownership	Yes ☐	No ☐	Date: ___/___/___
Store sold	Yes ☐	No ☐	Date: ___/___/___
New owner	Yes ☐	No ☐	Date: ___/___/___
Store moved to new address	Yes ☐	No ☐	Date: ___/___/___

Other _____

Changed Bank Yes ☐ No ☐ Date: ___/___/___

If yes to any of the above questions, give details.

_____

_____

_____

Attach (tape) a <u>permanent</u> blank voided check from your branch's established account for deposit of WIC checks.

Rhode Island Department of Health
WIC Program

Automated Clearinghouse (ACH) Authorization Agreement

FOR REIMBURSEMENT CREDITS or PAYMENT ADJUSTMENTS AT PEER GROUP MAXIMUM PRICE (ACH CREDITS)
AND PENALTY OR FEE COLLECTION (ACH DEBITS)

This form should be completed (for each store) by either the store owner, partner or the WIC registered authority only

Business Name: _____ Today's Date: _____

Pharmacy Name: _____ Specify, if a different bank accounts: _____

Name on Store Signs (dba): _____ Store Phone No: _____

Store Address: _____ City: _____ Zip Code: _____

Bank report should be mailed to this address: _____

City: _____ State: _____ Zip Code: _____

Full Legal Owner's (Person's) Name(s): _____
(print)

Full Legal Account Holder's (Person's) Name(s): _____ Title: _____
(print)

Full Legal Account Holder's (Person's) Signature: _____ / _____
(Original Authorized Legal Signature(s))

I (we) hereby authorize and request the RHODE ISLAND DEPARTMENT OF HEALTH - WIC PROGRAM, hereinafter called HEALTH, to initiate and effect Reimbursement or Payment Credit and/or Penalty or Fee Collection entries of any amounts owing by HEALTH to me (us) and any amounts owing by me (us) to HEALTH as such amounts become due by initiating Reimbursement or Payment Credit and/or Penalty or Fee Collection (and the ability to perform a reversal of an erroneous transaction) entries related to WIC transactions to my (our) checking and/or savings account indicated in the bank name(s) below, hereinafter called BANK and I (we) authorize and request the BANK to direct/accept the entries related to WIC transactions initiated by HEALTH to such account(s) without responsibility for the correctness thereof. Reimbursement or Payment Credit will be initiated if a WIC check is submitted for payment above the current maximum price for my peer group. I agree to accept an adjusted ACH Credit and any related fees if the price on the WIC check(s) submitted for payment exceeds the current maximum price for my peer group. I (we) (the signor above) certify that I have the legal authority to sign this agreement.

ANY MODIFICATION TO ACCOUNT INFORMATION MUST BE REPORTED IMMEDIATELY

Depository Bank Name: _____

City: _____ State: _____ Zip: _____

Routing Number _____ Account Number _____

Please verify your routing transit and accounts number with your bank or business office before completing this section.

I (we) with the above signature, certify that all the above information is true. I (we) understand that WIC Program officials may verify any information relating to this certification; and that if I (we) have contributed to any misrepresentation or falsification of information, participation as a WIC Vendor will be subject to permanent disqualification, denial and/or termination from the WIC Program up to six years, claim for reimbursement and possible disqualification from the Food Stamp Program and criminal prosecution.

This authorization is to remain in full force and effective until the RHODE ISLAND DEPARTMENT OF HEALTH - WIC PROGRAM has received written notification from me (us) of its termination

Subscribed and sworn to before me this _____ day of _____, 20 _____. SEAL

Original
Signature: _____ **Print** _____ **Commission Expires** _____

MUST BE NOTARIZED

As this person's notary you are certifying that this signature is the original and authentic signature of the business owner who is completing this application form.
Notaries are covered under the WIC Law and Regulations associated with any violations that may occur with this application process